“I did then what I knew best, when I knew better, I did better.”

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Statement of confidentiality:

It is the intention of this work to protect the anonymity of all service users, colleagues and carers within this document. It is a core requirement of the Nursing and Midwifery Council code of conduct (NMC, 2015) that confidentiality be preserved.

Introduction:

Schön (1983) introduced the concept of reflection-on action which is used in a broad range of disciplines (Stonehouse, 2015) to contextualise and develop experienced based learning. John's model of reflection was developed to structure the reflective process, thereby making it more effective in informing practice (John, 1995). Based on "Carper's fundamental ways of knowing" (John, 1995 p.226), John's model is designed to direct learning and encompasses different aspects of knowledge in practice; "empirical, ethical, personal, and aesthetic ways of knowing" (John, 1995 p 227). It is the dynamic interplay of these areas of knowledge that determine the effectiveness of nursing practice (John, 1995).

The Nursing and Midwifery Council (NMC) code of conduct advises that a nurse should "work with colleagues to evaluate the quality of your work and that of the team"(NMC, 2015 p. 8). Participating in a syndicate group, (including a mentor, a professor and other students) allowed for critical exploration of an event. Critically evaluating nursing practice can be seen as fundamental in improving the quality of care (Breadon & McColgan, 2012). Banks et al, (2013) maintain that the current structure of clinical supervision within nursing maintains a status quo and advocates for clinical supervisors from other disciplines to facilitate alternate perspectives and greater depth of analysis and reflection.

During discussions within the syndicate group there was a shift in focus to an exploration of professional decision making, resources management and application of legislation. The change in perspective or "facilitated reflection" (Breadon &

McColgan, 2012 p 10) could not have been achieved without exploratory questions on the incident (Harpen, 2009). Discovering "blind spots" (Harpen, 2009 p 11) allowed for exploration of aspects of practice that I had not considered for exploration. John's reflective model, reminds us to consider the purpose of an intervention (John, 1995). For the purpose of this reflection the model has been modified (John, 1995) to focus consideration of "legal, ethical and professional issues" (Casey, 2015).

Incident:

Jane (not her real name) was to be admitted to a specialist unit in Yorkshire, she failed to attend on the agreed date and avoided contact with the service. Jane's grandmother, her carer and primary carer for her son, acted as intermediary while Jane stayed in bed at home. Later, Jane agreed to the admission; attended the ward, participated in the admission process stayed one night but then decided to discharge herself the following Monday after weekend home leave.

This was her second time on the ward and many of the nurses and allied health professionals within the team (occupational therapists and health care assistants) had experience of her as a service user. Jane's initial admittance had been due to her delayed recovery after serious complications from the birth of her first child and lack of attachment to the child. After a number of physiological tests; the lack of any organic reason for the delay in recovery, she was referred to the specialist mental health unit. The previous admission had been difficult with concerns about Jane's engagement with the care plan and self-destructive behaviour.

Her new admission was due to concerns expressed by Jane herself and her family at the re-emergence of previous physical symptoms; concerns expressed by her family in connection with her behaviour and attachment to her son. She had been visited and assessed as suitable for admission by members of the nursing team and one of the doctors. Jane's family had been consulted; initially they agreed to the admission but then supported her decision to leave.

Reflection:

My mentor, as primary nurse, was involved in the assessment and the decision to admit. This involved an initial assessment, which included checking that Jane met the criteria for admission on to the ward, a discussion with carers and that the treatment offered would be beneficial to Jane. As part of my nurse training, the intention was that I would be involved in Jane's admission onto the ward and be part of her primary nursing team. However, as Jane chose not to attend on the day that had been arranged for her admission, and I was not at placement on the alternate date, this involvement was not possible. The decision not to change placement days to accommodate this change was due in part to opinions expressed by the team that Jane might change her admittance date again. Witteman et al., (2012) discusses the concept of knowing people or the "clinical method" (Witteman et al., 2012 p.20) where divergent sources of information are combined with personal experience to inform decision making. The concept is similar to "Carper's fundamental ways of knowing" (John, 1995 p. 226) which has been criticised in nurse education due to the difficulty in defining aesthetic knowledge (Cloutier et al, 2007).

The code includes instruction to use “best available evidence” (NMC, 2015 p.7), however this in itself does not challenge the use of “professional intuition” (Witteman, et al 2012 p.20) as the best evidence will be from the service user (Slade, 2009, p. 57). However, in defining that “information or advice given is evidence based” (NMC, 2015 p.7) there is a clear instruction to use empirical evidence. There is a danger when applying “professional intuition” (Witteman, et al 2012 p.20) that the conclusions are seen as a fact rather than a hypothesis (Slade, 2009, Witteman et al, 2012). Jane was admitted onto the ward on the day she agreed. However, her stay, as anticipated by some practitioners, was brief so even if I had participated in her admission I would not have been able to work with her. Witteman et al (2012) suggest that when coupled with evidence based practice (NMC, 2015) the use of “professional intuition” (Witteman, et al 2012 p 20) can increase a person centred holistic approach (NMC, 2015 p. 4-5) and improve decision making (Witteman et al, 2012).

Mental health nurses are required to maintain a “recovery-focused practice” (NMC, 2010 p.23) as one of the standards for pre-registration. Slade, (2009) argues that empowering the service user in taking responsibility for their own recovery can generate ethical dilemmas. The difficulty is in “balancing conflicting values” (Slade, 2009 p. 61) where answerability as a professional is in conflict with encouraging “personal responsibility” (Slade, 2009 p. 78).in the service user, which is one of the “four key domains of personal recovery” (Slade, 2009 p.78). Jane made a decision not to attend for admission to hospital. In making that decision she was exercising her autonomy (Gillian, 1994), however that decision had implications for the service. There was time spent preparing for the admission including the room preparation,

ordering food for the evening meal and the allocation of staff to complete the admissions process. The admissions process includes psychosocial base line assessments which are repeated on discharge and at periods after discharge to ascertain the effectiveness of the service. The resources that were not used have a cost value and the National Health Service (NHS) has limited resources available to use for patient care. This would be an area where encouraging autonomy conflicts with professional responsibilities to "manage, time, staff and resources" (NMC, 2015 p 18), however the principle is that these elements are managed for the benefit of those "receiving care" (NMC, 2015 p.18). Prioritising cost was evident in the lack of care received by patients in North Staffordshire (Francis, 2013).

In recounting the incident during the syndicate group, I offered a variety of explanations for Janes' departure; her extended families involvement, her previous lack of engagement with the in-patient care plan and the implications of the trusts smoking policy. I realised that these hypostosis had been generated through conversations with the nursing team, particularly members that had been involved with Jane's previous admittance to the ward. Jane's arrival generated discussion, as did her departure. It is necessary to "work co-operatively" (NMC, 2015 p.8) with colleagues and "maintain effective communication" (NMC, 2015 p.8). The intention in discussing Jane's previous admission was that I would be directly involved with Janes primary care team as part of my nurse training. In terms of information sharing (NMC, 2015 p. 6) the intention was to provide appropriate care for Jane and manage any risk (Department of Health (DOH), 2007). In her previous admission Jane had gone missing from the ward which had generated concerns about her

safety. Millar and Sands (2013) argue the importance of ensuring that risks are properly communicated when transferring the care of a service user (DOH, 2007).

The discussion about the possible reasons for her departure was to examine the possible barriers to Jane receiving treatment and consider if anything needed to change in the admission process or if the barriers to treatment were outside the scope of the service to change (NMC, 2015 p.8). Delays in accessing treatment for mental health difficulties can be attributed in part to the stigma associated with a mental health diagnosis (Dockeryn et al., 2015) and would be an example of a barrier that is outside the scope of the service. The converse situation of readily accessing services can be true when a mental health condition manifests as a physical disability or illness (Hahn, 2001). Hahn (2001), identifies the social benefits of maintaining a sick role in the reduction of expectations placed on the person.

A position within the team of student or learner allowed for exploration with colleagues of the principals of decision making, so that I was able to understand more fully the reasons for their conclusions about Jane. Conclusions were based on "professional intuition" (Witteman, et al, 2012 p.20), empirical evidence and a critical evaluation of the policies and procedures within the hospital and the trust in relation to the service user. Slade (2009) would identify this as using "clinical judgement" (Slade, 2009 p 61). Witteman et al (2012) notes some concerns with the use of intuition alone as producing "tunnel vision, projection and/or confirmation bias" (Witteman et al, 2012 p. 24). Scheick, (2011) identifies the potential for counter-transference in therapeutic relationships (Witteman et al, 2012), where the nurses own concerns are identified in the suffering of the service user and has an adverse

effect on the therapeutic relationship (Scheick, 2011). Although the discussions identified a number of possible barriers to Jane's admittance onto the ward for treatment and the management difficulties (given knowledge of her previous admission) there was an absence of reflection collectively of the personal impact on staff. However, this may have been addressed in private reflection and personal supervision or during her previous admission. Rasheed (2015) identifies the need to develop self-awareness through reflective practice in supporting a therapeutic relationship and providing care. The potential for bias when using "professional intuition" (Witteman, et al, 2012 p.20) or "clinical judgement" (Slade, 2009 p 61) can be mitigated when decision making takes place within a team context (Slade, 2009).

The general impression was that Jane was viewed as a "difficult patient" (Fiester, 2012 p.2) by some members of the team. Fiester (2012) although considering the American model of health care identifies themes which are transferable; that interactions with organisations can produce justified feelings of vulnerability in service users that in turn produce understandable hostility and destructive behaviour testing the nurse-service user relationship. Hahn, (2001) identifies frustration in medical practitioners when there is an inability to diagnose organic disease, which may be communicated to the service user. I had little opportunity to interact with Jane. I met her when she had returned to the ward to meet the doctor prior to her discharge, however the brief interaction was respectful and friendly. I was disappointed that I would not have the opportunity to work with Jane. However, I maintained the belief that if she did not feel it was the right time for her to examine her situation or that an inpatient service did not suit her social needs, then she had the right to make that decision (NMC, 2015 p 15). Mitchell (2010) discusses the

importance of respect in promoting dignity for a service user. Preserving dignity is included in the code (NMC, 2015 p 4 & 16) and does not only concern physical privacy but rather an intention to act with respect to another recognising their status as a person (Mitchell, 2010). The important consideration in terms of biomedical ethics would be to do no harm (non-maleficence) (Gillian, 1994). Slade (2009) argues that compulsory treatment for mental health conditions, where beneficence (Gillian, 1994) is given prominence as an ethical consideration, can produce dependence which is the antithesis of recovery.

Jane was admitted onto the ward as she consented to treatment. Capacity is assumed in law (Mental Capacity Act (MCA), 2005). As part of the admissions process on to the ward, the ability to consent to treatment was assessed and the outcome recorded. The NMC code identifies the importance of correct records (NMC, 2015, p 10) to allow for the best treatment for people receiving care. It is the role of the primary nurse for a service user to ensure that a capacity assessment had been completed and recorded. The assessment of capacity, given the presumption of capacity (MCA, 2005) would appear redundant and contrary to the principal of autonomy (Gillian, 1994). If this process is contradictory to biomedical ethical principles of autonomy (Slade, 2009) and legality (MCA, 2005) then this could present an ethical dilemma.

Sorinmade et al., (2015) identify the difficulties in practice of choosing either the Mental Capacity Act (MCA) 2005 or the MHA 1983 where a service user is informally admitted for mental health concerns, lacks capacity and could be “considered to be

objectively deprived of their liberty" (Sorinmade et al. 2015 p 32) under section 5 of the European Convention of Human Rights (ECHR, n.d.). The NMC code encourages a nurse to "uphold human rights" (NMC, 2015 p. 2) so understanding those rights to liberty, particularly in relation to acts of parliament would be important (Bingham, 2012). Bingham (2012) recounts an occasion where the wishes of a patient was respected and another where the wishes of the patient were superseded by the clinicians' judgement, both circumstances were held to be lawful. This demonstrates the complexity of the law in relation to mental health nursing practice.

After a discussion with the doctor involved in assessments, the decision to assess capacity during the admittance process is based on concerns that the ward circumstances constituted a deprivation of the service users' liberty (Sorinmade et al, 2015). The particulars of the ward did not meet many of the criteria for depravation of liberty (Sorinmade et al, 2015 p.35) particularly as it was not a locked ward so it is unlikely that service users could be considered to be detained on the ward (Sorinmade et al, 2015). However, some service users, due to the presentation of their mental illness through physical disability were incapable of leaving the ward without support, so the concerns around "depravation of liberty" (Sorinmade et al., 2015 p32) and the implementation of a practice before case law established criteria (Sorimade et al, 2015) were understandable.

The consideration of capacity was part of a wider discussion around treatment and gaining written consent for the treatment plan. This written consent was revisited weekly after a multidisciplinary meeting (ideally involving the service user) when

changes in the care plan were agreed. Consent was also gained verbally at every intervention (NMC, 2015 p. 6). There was a potential that capacity would be assumed by staff when gaining consent for interventions as a capacity assessment had been completed and recorded. If a person does not have capacity then they are unable to consent to treatment (MCA, 2005, Sorinmade et al. 2015) and a best interest decision would be made (Mental Capacity Act (MCA), 2005). In these circumstances a consideration of capacity when obtaining consent for treatment or intervention is necessary for consent to be valid (Department of Health (DOH), 2009) and in the service users "best interests" (NMC, 2015 p 5). This consideration of "best interests" (NMC, 2015 p. 15) would not be under the MCA 2005 but rather under the code of conduct (NMC, 2015).

Within mental health services there is a tension between beneficence (benefiting the service user) and respecting autonomy (the service user making decisions) (Mitchell, 2010). The Mental Health Act (MHA) 1983 can be used for paternalistic beneficence if an individual is assessed as lacking the competence to make treatment decisions (Mitchell, 2010) and allows for compulsory treatment (MHA, 1983, Atkinson, 2010). Critical incidents such as fatal stabbings by service users has encouraged a culture of aversion to risk and an increase in the public perception of the risk that someone with mental health difficulties may pose to others (Hall, 2013). This has the potential to limit the freedoms of people suffering with mental illness (Hall, 2013) and adversely affect recovery by reducing opportunities for self-development (Slade, 2009 p. 59).

Not every person who has a mental illness requires detention (DOH, 2015). The NMC code requires acting in the "best interest of people" (NMC, 2015 p 5) which includes accepting their right to decline treatment (NMC, 2015 p 5). The MCA 2005 allows for unwise choices, with the provision that the person understands the consequence of those decisions (MCA, 2005). Jane discharged herself from hospital. The doctor concluded that she had capacity to refuse treatment and did not meet the requirements for detention under the MHA 1983. Collaboration, not only with the service user but also with colleagues is another aspect of the code of practice (NMC, 2015, p. 8); the doctor had the most appropriate skills and authority to make these determinations (MHA, 1983).

Reflexivity:

Working to understand the rationale behind the acceptance of Jane's refusal to accept in patient treatment has developed a greater understanding of the interaction between various legislations (MHA, 1983 and MCA, 2005) and the code of practice (NMC, 2015). This development of empirical knowledge (John, 1995) of the MHA, 1983, the MCA, 2005, the guidance on the MHA 1983 (DOH, 2015) can be used to inform future practice when making decisions and advocating for service users (NMC, 2015 p 13). Within the particular service a review of the practice of assessing capacity after case law decisions (Sorimade et al, 2015) might be beneficial. However, the principle that valid consent requires capacity, information and is made without coercion (DOH, 2009) would need to be maintained.

The ethical considerations within mental health nursing are complex as Bingham (2012) identifies. In considering the decision making process of nurses within

practice situations I have begun to understand the complexities of applying these principals to practice, particularly when two biomedical principles conflict (Mitchell, 2010). I found the discussion of principals from different perspectives challenged my understanding and offered alternate ways of considering the application of professional (NMC, 2015), biomedical (Gillion, 1994) and legal considerations. It would be helpful while developing "professional intuition" (Witteman, 2015 p.20) and gaining experience to consult with colleagues when making ethical choices.

In order to be completely "patient-centred" (NMC, 2010 p.23) and maintain a recovery focus (NMC, 2010 p.23), the placement area evaluated performance in relation to the continued recovery of the service user. A different placement area focused on the time spent admitted to the ward to evaluate effectiveness. In considering the purpose of mental health care as recovery (Slade, 2009, DOH, 2011) this would appear a more accurate measure of the effectiveness of the treatment offered.

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